THE UNIVERSITY OF TENNESSEE SYSTEM

WORKERS' COMPENSATION INJURED WORKER STATEMENT

Supervisors must provide this form to **all** injured workers to complete concerning the injury/illness. This form must be completed in its entirety by the injured worker and supervisor and should be an accurate and truthful account of the injury/illness.
Signatures are required.

Check one: *Near Miss or Incident Only - No Treatment* ☐ *Accident Resulting in First Aid Only* ☐ *Accident Resulting in Injury* ☐

REQUIRED - CORVEL CLAIM NUMBER: 0546-WC- ____- _____

SECTION 1: INJURED WORKER (IW) PERSONAL INFORMATION

First Name _____MI ___ Last Name _____

Personnel #_____ PH#_____ Email_____

Home Address_____City_____State_____Zip_____

SECTION 2: INJURED WORKER EMPLOYMENT INFORMATION

Campus Choose one: Department_____Title_____

Work Location Address_____

Supervisor_____PH#_____Email_____

SECTION 3: INJURY DETAILS

Date of Injury _____ Date Injury Reported _____

Who Reported Injury? _____ Any witnesses? Yes ☐ No ☐

If Yes, Witness Name(s) Contact Info_____

Body part(s) injured

_____

_____

Injury description and details

_____

_____

_____

Prior to this accident/incident, have you ever hurt, suffered an injury, or received treatment for the body part(s)listed in the question above Yes ☐ No ☐

If yes, please provide the date of the injury, type of injury, and names of treating physician(s)

_____

_____

_____

Cause of Accident

_____

_____

_____

Questions about this form? Contact the System Office of Risk Management:
865-974-5409

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SECTION 4: DETAILS CONT'D

Physical address/location where the accident occurred

_____
_____

What job duties were being performed?

_____
_____

Were you sent for treatment? Yes ☐ No ☐

If yes, where_____

COMMENTS:

_____
_____
_____

SECTION 5: INJURED WORKER ATTESTATION

INJURED WORKER: I hereby certify that the above-referenced information is true and accurate. I further understand that the information above will be used by CorVel/State of TN to help determine compensability for my injury and that any inaccurate or false statements offered may result in a delay in processing my claim and/or denial of my request for Workers' Compensation Benefits. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines, and denial of insurance benefits.

Injured Workers' Printed Name _____

Injured Workers' Signature_____Date_____

Submit the completed form, no later than 48 hours from the date of injury to the System Office of Risk Management:
riskmanagement@tennessee.edu

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